STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055105	A. Building B. Wing	01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royal Vista Care Center	909 W. Santa Anita Ave San Gabriel, CA 91776

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on interview and record review, the facility failed to implement the comprehensive care plan related to alleged rough handling by staff for one of one sampled resident (Resident 1) in accordance with the facility policy. This deficient practice had the potential to result in delay or lack of delivery of care and services to Resident 1 which could affect resident's overall wellbeing. Findings: During a review of Resident 1's Admission Record (front page of the chart that contains a summary of basic information about the resident), the admission record indicated Resident 1 was originally admitted to the facility on [DATE]. Resident 1's diagnoses included dysphagia (difficulty swallowing), pneumonia (an infection/inflammation in the lungs), and hypertension (HTN-high blood pressure). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 10/9/2024, the MDS indicated Resident 1 was moderately impaired (decisions poor; cues/supervision required) with cognitive (processes of thinking and reasoning) skills for daily decision making. It also indicated Resident 1was dependent (helper does all the effort. Resident does none of the effort to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 1's care plan focusing on Resident 1's complaint against an employee, alleging that he was handled roughly. The staff interventions included the following: Addresses physical pain and emotional distress, including anxiety (fear characterized by behavioral disturbances) and depression (mood disorder that causes a persistent feeling of sadness and loss of interest). Encourage resident to verbalize any signs of further abuse. Ensure a safe and secure environment. Ensure that resident feel his needs and preferences are respected for overall satisfaction and comfort. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure to reduce patient's fear, improve psychological functioning. Involving resident and family in care planning to empowers them to voice concerns and preferences, making it harder for abuse (the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish) or neglect to go unnoticed. Provide emotional support and listening without judgement. Tailoring care to individual needs to ensure that resident's health and comfort are prioritized. During a review of Resident 1's SBAR/Change of condition (COC) notes, dated 1/7/2025, indicated Resident 1 reported an alleged abuse by staff member. During a concurrent interview and record review on 1/10/2025 at 7:14 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 1's electronic medical records was reviewed. LVN 1 stated Resident 1 has an SBAR on 1/7/2025 regarding alleged abuse from staff member. LVN 1 stated Resident 1 was not and should have been placed on 72 hours monitoring for psychosocial wellbeing. LVN 1 stated the Licensed nurses should have monitored and documented Resident 1's status every eight hours for 72 hours. During a concurrent interview and record review on 1/10/2025 at 12:50 AM with MDS nurse (MDSN), Resident 1's electronic medical records were reviewed. MDSN verified Resident 1 did not have a COC note indicating Resident 1 was monitored by the Licensed Nurse after reporting an alleged abuse on 1/7/2025. MDSN stated it was important to implement the care plan interventions and have a documentation regarding Resident 1's emotional distress, including anxiety and depression after Resident 1 reported an alleged abuse to know if Resident 1 has changes in psychosocial state (a person's mental, emotional, social, and spiritual well-being) and to further assess the need for treatment. MDSN verified there was no Licensed Nurse documentation addressing the implementation of Resident 1's care plan interventions for the alleged rough handling by staff. During a concurrent interview and record review on 1/10/2025 at 1:11 PM with the Director of Nursing (DON), Resident 1's medical records were reviewed. The DON verified Licensed nurses did not have a COC documentation for Resident 1 since 1/7/205. The DON stated COC documentation is being done for a minimum of 72 hours, and documentation every 8 hours by Licensed nurses. The DON stated Resident 1 has a care plan regarding the alleged rough handling by a staff member, but there is no documentation that Resident 1 was being monitored. The DON stated it was important for Resident 1's care plan to be implemented so the staff would know how to care for Resident 1 after reporting an alleged rough handling by staff. During a review of facility's Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. During a review of Facility's P&P titled, Change in a Resident's Condition or Status, revised in February 2021, the P&P indicated the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46087 Based on observation, interview, and record review, the facility failed to follow its infection control policy for one (1) of two (2) sampled residents (Resident 1) by failing to ensure staff were using a gown while rendering diaper change and administering medication via gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for residents with swallowing problems) tube to Resident 1 who was on enhanced barrier precaution (EBP, an infection control practice that involves wearing gowns and gloves during high-contact activities with residents in nursing homes). This deficient practice had the potential to result in Resident 1 developing an infection and spread of infection among staff and residents. Findings: During a review of Resident 1's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated Resident 1 was originally admitted to the facility on [DATE]. Resident 1's diagnoses included dysphagia (difficulty swallowing), pneumonia (an infection/inflammation in the lungs), and hypertension (HTN-high blood pressure). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 10/9/2024, the MDS indicated Resident 1 was moderately impaired (decisions poor; cues/supervision required) with cognitive (processes of thinking and reasoning) skills for daily decision making. It also indicated Resident 1was dependent (helper does all the effort. Resident does none of the effort to complete the activity) with eating, oral hygiene, toileting hygiene, shower/bath, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During an observation on 1/8/2025 at 3:40 PM, an EBP signage was observed outside Resident 1 ' s room but there was no personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) cart observed During an observation on 1/10/2025 at 6:19 AM in Resident 1 ' s room, with Certified Nurse Assistant 1 (CNA 1) and CNA 2, both CNAs were not observed wearing a gown while providing incontinent care treatment to Resident 1. During an interview with CNA 2 on 1/10/2025 at 6:20 AM, CNA 2 stated that she did not wear a gown when she was in Resident 1 ' s room because she was only there to hand towels to CNA 1 while he was rendering care (peri care [washing the genitals and anal area], diaper change) to Resident 1. CNA 2 stated CNA 1 should have worn a gown and not only gloves during incontinent care. CNA 2 stated that there was no PPE cart outside Resident 1 ' s room to alert staff and visitors to wear appropriate PPE while rendering close contact care to Resident 1. During an interview with CNA 1 on 1/10/2025 at 6:27 AM, CNA 1 stated I don ' t know anything about the resident, it ' s my first time handling him. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/10/2025 at 6:28 AM with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated EBP should be implemented for Resident 1 because he has a G-tube. LVN 1 stated CNA 1 should have worn a gown while giving care to Resident 1 because staff were in close contact with Resident 1. LVN 1 verified an EBP signage was outside Resident 1 ' s room, but there was no PPE cart. LVN 1 added that EBP should have been ordered and added in Resident 1 ' s care plan. During an observation on 1/10/2025 at 8:47 AM in Resident 1 ' s room, LVN 2 was observed administering medication to Resident 1 through the resident ' s G-tube without wearing a gown. During a concurrent observation and interview on 1/10/2025 at 8:48 AM with Treatment Nurse (TN), TN verified LVN 2 was not wearing a gown during medication administration through Resident 1 ' s G-tube. TN verified an EBP signage and PPE cart was placed outside Resident 1 ' s room. TN stated the facility does adhere to EBP, wherein PPE, such as wearing gown, gloves, and mask, needs to be worn during physical contact care like medication administration via G-tube. TN1 stated wearing PPE was important to protect the resident. TN stated staff providing care to Resident 1 should wear the proper PPE for infection control because Resident 1 has a G-tube. During an interview on 1/10/2025 at 11:06 AM with LVN 2, LVN 2 stated he did not wear a gown when he administered medications through Resident 1 ' s G-tube. LVN 2 stated that he should have also worn a gown and not only gloves during close contact with Resident 1. During a concurrent interview and record review on 1/10/2025 at 1:10 PM with Director of Nursing (DON), Resident 1 ' s medical records were reviewed. The DON verified EBP was not in Resident 1 ' s active orders. The DON also stated Resident 1 has no care plan for EBP. The DON stated PPE requirements for EBP is for staff to wear gloves and gowns during high contact care activities for residents on EBP. The DON stated CNA 1 and LVN 2 should have worn a gown during incontinent care and medication administration through G-tube because both staff were in close contact with Resident 1. During a review of facility ' s Policy and Procedure (P&P) titled, Enhanced Barrier Precaution, dated October 2024, the P&P indicated Enhanced Barrier Precautions is to prevent the transmission of multidrug-resistant organisms (MDROs, a bacteria that does not respond to antibiotics) and other infectious agents (organisms that can cause disease) while ensuring that residents experience a homelike, comfortable environment. The set of practices include the use of PPE like gowns and gloves during high-contact resident care activities. It also indicated the following high contact resident activities: Dressing Grooming Bathing/showering Oral care, brushing teeth Transferring Providing hygiene/ peri-care (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Changing linens Changing briefs Device care: feeding tube Medical treatment related to the use of the device such as administering tube feedings/medications. The P&P indicated gowns and gloves will be available immediately near or outside of the resident's room